University Graduate Assistant Continuants Group Health Insurance Application

Instructions for Dual-Choice Enrollment

If you are an active employee, you may not use this application.

You must file this application by the end of the Dual-Choice Enrollment period if you want to change to a different health insurance plan or change to family coverage for the following year. If you wish to keep the same plan, but have other changes (e.g., adding or dropping a dependent, change of physician only, change of address or name) contact Employee Trust Funds to obtain the appropriate form.

Please read the instructions carefully. To avoid delays it is very important that you complete your application accurately.

1. **Name –** Complete your full name, including your middle name.

2. **Plan Name and Group No.** - This information is needed so that your current health insurance can be cancelled and your new plan can take effect. The group number can be found on your current health insurance I.D. card.

3. **New Group Health Insurance Plan Selected** - In this box write: "Standard Plan," or the name of the alternate plan you have selected.

4. **Other coverage** - Complete this indicating if you or anyone you list on your application is currently insured by another group health insurance policy**. This area must be completed in order to process the application.** If you or anyone you list on your application is enrolled in Medicare, list and provide Medicare effective dates.

5. **Persons to be covered** - Make sure you list each person to be covered under the health insurance plan you are selecting and include their Social Security numbers.

6. **Appl. Rel.** - Indicate your listed dependent's relationship to you (S-Son, D-Daughter, SS-Stepson, SD-Stepdaughter, G-Grandchild, LW-Legal Ward).

7. **Student Status –** Indicate your dependent's student status if age 19 or older for 2004 (Y=Yes has student status, N=No, does not have student status).

8. **Selected Physician** - Indicate the *first and last name and county* of your primary physician. If available, list your physician's *provider number*. Write **none** if you have chosen the Standard Plan.

9. **Sign and date** - Make sure you sign and date your application.

10. Send your application to:

    Employee Trust Funds
    P. O. Box 7931
    Madison, WI 53707-7931

11. **Your application must be postmarked by the last day of the Dual-Choice Enrollment period (October 24, 2003). LATE APPLICATIONS WILL NOT BE ACCEPTED.**

GRADUATE ASSISTANT CONTINUANTS ONLY

GROUP: **GRADUATE ASSISTANT CONTINUANT** **DUAL-CHOICE** HEALTH INSURANCE APPLICATION

Applicant – Last Name	First	Middle	Social Security Number

Address – Street & No.	City	State	Postal Code	County	Home Telephone Number ( )

Marital Status ☐ Single ☐ Married Date_____ ☐ Divorced Date_____ ☐ Separated Date_____ ☐ Widowed Date_____

Instructions:

To change plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

PLEASE PRINT

Spouse's/Ex-Spouse's Name & Social Security Number

CURRENT GROUP HEALTH INSURANCE PLAN

Plan Name _____

Group No. _____

NEW GROUP HEALTH INSURANCE PLAN SELECTED

Plan Name _____
(*list complete name, including location if part of name)*

COVERAGE DESIRED

☐ Single ☐ Family

OTHER HEALTH INSURANCE COVERAGE (*You must complete this section*)

Are you or a family member insured under Medicare? ☐ No ☐ Yes

If yes, list names of insured and Medicare effective dates.

Name: _____ Dates: Part A _____ Part B _____

Name (spouse):_____ Dates: Part A _____ Part B _____

Are you or a family member insured under another health insurance plan? ☐ No ☐ Yes

If yes, list names of insured and plan.

Name: _____

Name (Spouse): _____

Plan Name (Insurance Co.): _____

Group No.: _____ Subscriber (Policy) No.: _____ Name of Employer:_____

Last Name	First	Middle	Birthdate MO	DAY	YR	Sex M/F	Social Security Number	(see page H-2) Appl. Rel. Code	Student Status	**YOU MUST INDICATE SELECTED PRIMARY PHYSICIAN, COUNTY** in which located, and **PROVIDER NUMBER** (if available). Indicate **NONE** if electing Standard, Standard II or Medicare Plus $100,000. PHYSICIAN NAME First & Last	PHYSICIAN'S COUNTY	PROVIDER NUMBER
Applicant								N/A	N/A			
Spouse								N/A	N/A			
Eligible Dependent(s)												

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. **Submit form with original signature.**

☐ I am a retiree or surviving spouse/dependent ☐ I am on continuation (eligible for a maximum of 36 months' coverage)	DATE SIGNED (MM/DD/CCYY)	APPLICANT SIGNATURE **SIGN HERE**

Return completed form to: Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be **effective 01/01/2004**

FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY

ENROLLMENT TYPE	EMPLOYEE TYPE	COVERAGE CODE	CARRIER SUFFIX	PARTICIPANT'S COUNTY	PROVIDER'S COUNTY
40	13				

EIN	Group Number	ETF Contact Person	Telephone
0000-001	83509		(608)

Monthly Premium	Date Received	COBRA Coverage Expires	Effective Date
$			01/01/2004

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.

2. I agree to pay the current premium for this insurance.

3. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me, my spouse or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.

4. Any children listed on this application are unmarried and dependent on me, or the other parent, for support and maintenance. If over the age of 19, they are a full-time student; if over the age of 25, they are disabled of long standing duration and are incapable of self-support.

5. I understand that coverage will be cancelled and cannot be reinstated if premiums are not paid when due.